# **U.S. Department of Labor**

Office of Administrative Law Judges 800 K Street, NW, Suite 400-N Washington, DC 20001-8002

(202) 693-7300 (202) 693-7365 (FAX)



Date Issued: Oct. 27, 2000

Case No. 1999-BLA-0220

In the Matter of

LAURA L. WHITTINGTON, o/b/o JAMES B. WHITTINGTON, Deceased<sup>1</sup> Claimant

v.

CYRUS AMAX MINERALS CO., Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS, Party-in-Interest

**APPEARANCES:** 

H. John Taylor, Esquire For the Claimant

Mary Rich Maloy, Esquire For the Employer

BEFORE: EDWARD TERHUNE MILLER Administrative Law Judge

# **DECISION AND ORDER - AWARDING BENEFITS**

This proceeding involves a claim filed by James B. Whittington for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901, et seq., as amended ("Act"). The pertinent implementing regulations appear at Parts 718 and 725 of Title 20 of the Code of Federal Regulations. Because the claim was filed after March 31, 1980, Part 718 applies. Because the Claimant Miner was last employed as a coal miner in West Virginia, the law of the Fourth Circuit of the United States controls. See Shupe v. Director, OWCP, 12 BLR 1-200, 1-202 (1989)(en banc).

Black lung benefits are awarded to coal miners who are totally disabled due to pneumoconiosis within the meaning of the Act, or to the qualified survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs arising out of coal mine employment commonly known as black lung, and includes any chronic pulmonary

<sup>&</sup>lt;sup>1</sup>Laura L. Whittington is executrix of the estate of her deceased father, James B. Whittington, (CX 1)

disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. §718.201.

## **Procedural History**

On September 17, 1993, the Claimant coal miner filed a claim for benefits under the Act (DX 30-formerly DX 1). Following a formal hearing, Judge Neusner issued a Decision and Order dated August 1, 1995, denying benefits. Following the Claimant's timely appeal, the Benefits Review Board issued a Decision and Order (BRB No. 95-2066 BLA), dated December 9, 1996, affirming Judge Neusner's Decision and Order denying benefits. On October 14, 1997, the Claimant filed a request for reconsideration and modification. Since the request was filed within one year of the Board's Decision and Order, the modification request falls within the purview of §725.310 of the regulations. On November 21, 1997, the Claimant Miner died. (DX 30).

On February 5, 1998 and September 3, 1998, respectively, the District Director denied the modification request (DX 30). Following the timely request for a formal hearing, the claim was referred to the Office of Administrative Law Judges on November 10, 1998. A formal hearing was held in Beaver, West Virginia, on April 19, 1999. The documentary evidence which was admitted into evidence at the hearing consists of Director's Exhibit 30 (DX 30), which was the evidence pertaining to the Claimant Miner's claim, exclusive of the survivor's claim of his daughter, who is also his executrix. Claimant's Exhibit 1 (CX 1), and Employer's Exhibits 1-5 (EX 1-5) were also admitted. The daughter's survivor's claim was earlier dismissed. (TR 7-9,18-19,27-28). Pursuant to leave granted at the hearing (TR 29-30), the parties' post-hearing submissions have been marked as Claimant's Exhibit 2 (CX 2) and Employer's Exhibit 6 (EX 6), respectively, and admitted into evidence. The parties were afforded an opportunity to present evidence and argument at the hearing. The findings and conclusions that follow are based upon my observation of the appearance and the demeanor of the witness who testified at the hearing, and upon analysis of the entire record in light of the evidence, briefs, applicable statutory provisions, regulations, and pertinent case law.

<sup>&</sup>lt;sup>2</sup>Director's Exhibits 1-29 pertaining to the survivor's claim of the Miner's daughter were excluded on Employer's motion subject to further review as to materiality to the Miner's claim at the time of decision. Director's Exhibits 31 and 32, which were also excluded, technically are not evidence, though Exhibit 31 records the issues preserved at the time of file transfer to the Office of Administrative Judges. The numbering of exhibits is confusing, but it appears that Director's Exhibit 30 includes what can be styled numbered subexhibits 1-26, relating to the Miner's claim filed on September 17, 1993, resulting in an initial award of benefits by the District Director and forwarded for hearing; Director's subexhibit 27, relating to the Miner's claim filed March 22, 1978, which was withdrawn in 1980; Director's subexhibit 28, the controversion sheet dated June 7, 1994; and Director's subexhibit 29, containing the pleadings and evidence before Judge Neusner, which resulted in his Decision and Order denying the claim dated August 1, 1995, and the appeal which resulted in affirmation by the Benefits Review Board on December 9, 1996, and subsequent proceedings encompassed initially in Claimant's request for reconsideration.

## **Findings of Fact and Conclusions of Law**

## **Issues**

- 1. Whether the Claimant has established a change in conditions or a mistake in a determination of fact pursuant to §725.310.
- 2. Whether the miner had complicated pneumoconiosis;
- 3. Whether the miner was totally disabled within the meaning of the Act and regulations;
- 4. Whether the miner's total disability was due to pneumoconiosis.

The Employer has conceded timeliness of the claim, status as a miner, post-1969 employment, 43 years of coal mine employment, the existence of simple pneumoconiosis, causal relationship between the miner's simple pneumoconiosis and his coal mine employment, and its status as responsible operator (TR 12).

Except as otherwise superseded or modified, all of the analysis of evidence in Judge Neusner's Decision and Order, dated August 1, 1995, as affirmed by the Benefits Review Board on December 9, 1996, is incorporated by reference herein. Notwithstanding, since this claim is a request for modification, I have reviewed and analyzed the entire record.

In his Decision and Order denying benefits, Judge Neusner weighed the x-ray interpretations then of record and determined that the Claimant had established *simple* pneumoconiosis. Judge Neusner found that, although the record contained some evidence of complicated pneumoconiosis, the Claimant had not met his burden of establishing complicated pneumoconiosis based upon the totality of the x-ray evidence. In addition, Judge Neusner determined that none of the pulmonary function studies or arterial blood gas tests were qualifying under the regulatory criteria set forth in Part 718, Appendices B and C, respectively. Therefore, Claimant had not established total disability under §718.204(c)(1) or §718.204(c)(2). Since there was no evidence of cor pulmonale with right-sided congestive heart failure, the Claimant had not established total disability pursuant to §718.204(c)(3). Finally, Judge Neusner accorded greater weight to the opinion of Dr. Crisalli, as supported by the opinions of Drs. Chillag and Castle, over the opinion of Dr. Rasmussen, as partially supported by Dr. Gaziano, in concluding that the Claimant had not established total disability under §718.204(c)(4). On appeal, the Board affirmed. In doing so the Board expressly rejected Claimant's arguments regarding the existence of complicated pneumoconiosis, and the existence of total disability based on the medical opinion evidence.

## New Lay Evidence

Laura L. Whittington, the Claimant Miner's daughter and executrix, testified that she had lived with her father since 1992, when she moved into his residence shortly after her mother died in order to help take care of him. Ms. Whittington stated that her father was not in good health, and was unable to take care of himself. (TR 20-21) Ms. Whittington testified that her father suffered from shortness of breath which worsened over the years. She noted that he had been hospitalized in November 1992 with pneumonia, and that he had been treated by Dr. D'Brot.(TR 21). As his condition worsened, he was treated with three or four different inhalers, a nebulizer, and, ultimately, was placed on oxygen twenty-four hours per day (TR 21-22). In addition to pneumoconiosis, he suffered from diabetes and arthritis (TR 22).

Ms. Whittington also testified that her father was rushed to Charleston Area Medical Center in September 1997, because he was gasping for air and was weak. She discussed her father's condition with Dr. Crisalli, who was "on call" for Dr. D'Brot. Ms. Whittington stated that Dr. Crisalli had told her that her father should be receiving black lung benefits, because he has coal dust in his lungs. (TR 23-25). In addition, Ms. Whittington stated that Dr. Miller, a cardiologist, had told her that her father's heart was good, but his lungs were bad (TR 24-25). Ms. Whittington denied any finding of lung cancer prior to her father's death. She did acknowledge that her father had smoked cigarettes until he quit in November 1992, when he was hospitalized with pneumonia (TR 25-26).

#### New Medical Evidence

Material medical evidence dated subsequent to December 9, 1996, the date on which the Benefits Review Board affirmed Judge Neusner's Decision and Order denying benefits, dated August 1, 1995, is material to determination of whether the Claimant Miner is entitled to a modification of the prior denial.

Dr. Juan M. D'Brot's September 29, 1997, report diagnosed progressive pulmonary fibrosis due to occupational pneumoconiosis. He noted that he would continue large doses of systemic steroids as well as other inflammatory medications. Dr. D'Brot opined that the Miner's underlying lung disease had made him 100 per cent disabled and unable to carry on any activities. He declared that the prognosis due to his lung disease was quite dismal. The recommendation contained in an "attached report" consisted of results from a "walk" test, dated February 7, 1997. Dr. D'Brot noted, although the miner's breath sounds were "clear," "Patient very short of breath, had to rest frequently to catch his breath." (DX 30)

On November 20, 1997, the District Director's office sought a Medical Consultant Case Review with Dr. Ranavaya, who was asked, "What is the significance or relevance of the walk test in evaluating CWP? It shows the heart rate and 02 of SAT, but I don't know what the predicted values are, or exactly what this means, if anything, concerning CWP." In response Dr. Ranavaya stated:

I have reviewed the "walk test" in question & the report dated 2/7/97. While it appears to have some value in clinical use, the test has <u>no</u> value in determining a persons [sic] disability from pulmonary pathology. It is subjective factor. The O2 Sat above 90% correlates v. poorly with arterial PO2 & hence is of no value in determining disability. Therefore, this test cannot be relied upon in any decision process concerning CWP.

(DX 30).

The miner's death certificate, signed by Dr. D'Brot, records that the miner died on November 21, 1997, at age 72, of respiratory failure due to pulmonary fibrosis due to coal worker's pneumoconiosis. Although the death certificate states that an autopsy was performed (Item 28a), it does not specify whether the autopsy findings were available prior to the completion of the death certificate (Item 28b). (DX 30).

The autopsy was conducted on November 24, 1997, by Dr. Milton J. Plata, a pathologist at Charleston Area Medical Center who is board-certified in anatomic pathology and cytopathology<sup>3</sup>.

<sup>&</sup>lt;sup>3</sup>The professional credentials of Dr. Plata are not in evidence. However, this tribunal takes judicial notice that Dr. Plata's relevant qualifications are disclosed on the worldwide web,

Dr. Plata's report set forth the gross description and the microscopic findings regarding various parts of the body, the final anatomic diagnoses, and the cause of death (DX 30). In material part, the Gross Description of the Respiratory System and the Microscopic Findings of the Lungs, respectively, are as follows:

**RESPIRATORY SYSTEM:** ... Both lungs show similar changes. They consist of extensive black pigmentation of the pleural surface with areas of scarring and retraction. On sectioning the lung parenchyma shows numerous scattered coal macules (more than 0.3 cm in greatest dimension), larger black nodules measuring up to 0.8 cm in greatest dimension and also scattered blackened scars measuring up to 6.0 cm in greatest dimension. These larger areas are located around some mid-size bronchi. Also the hilar and mediastinal lymph nodes are diffusely black colored. There is an ill-defined area of lung parenchyma in the right upper lobe measuring up to 2 cm in diameter with a grey pasty consistency. This one is surrounded by scarring and black pigmentation. In addition there is moderate to severe pulmonary emphysema, more evident in the upper lobes. The lower lobes also show some congestion.... No pleural plaques are found.

LUNGS: Numerous sections from the lungs show black pigmentation associated with fibrosis on the pleural surfaces, pulmonary parenchyma, and hilar lymph nodes. These areas of fibrosis are of different sizes ranging from a few millimeters up to large masses within the pulmonary parenchyma. Also these areas of fibrosis and carbon pigment are associated with numerous silicotic nodules. Also there is severe pulmonary emphysema more evidently seen in the upper lobes. The bronchi show hypertrophic mucous glands associated with chronic inflammation of the submucosa and numerous mucous plugs in the bronchial lumina. Multiple areas of lung parenchyma show dilated alveolar spaces containing numerous acute inflammatory cells consistent with acute bronchopneumonia. These foci are seen in all lobes of both lungs except the right upper lobe.... Sections of the ill-defined mass found in the right upper lobe and surrounded by scarring and carbon deposits correspond to a well-differentiated keratinizing squamous cell carcinoma. The mediastinal and hilar lymph nodes show extensive anthracotic silicotic nodules. They show no evidence of metastatic carcinoma.

Dr. Plata's Final Anatomic Diagnosis recorded, in significant part, among the 17 final anatomic diagnoses the existence of severe aortocoronary atherosclerosis, healed myocardial infarcts, cardiomegaly, and bilateral ventricular hypertrophy, complicated coal workers' pneumoconiosis, severe chronic obstructive cell carcinoma of the lung, and bilateral diffuse fibrotic pleural adhesions. Dr. Plata did not explicitly diagnose progressive massive fibrosis. Nor does his report disclose how

American Board of Medical Specialties Public Education Program, Verification of Certification Results, at <a href="https://www.certifieddoctor.com">www.certifieddoctor.com</a>. See Maddaleni v. Pittsburgh & Midway Coal Mining Co., 14 BLR 1-135 (1990).

<sup>4</sup>The Clinical-Pathological Summary which appears in the autopsy protocol dated February 23, 1998, at DX 18 is not included in the protocol, which is otherwise identical, dated February 24, 1998, at DX 30. The extrinsic information would have been provided to the prosector and would be material only insofar as his opinion might have considered it. While it refers to congestive heart failure, there was no mention of congestive heart failure in the autopsy protocol.

any of the described lesions, suchy as the blackened scars or large masses of fibrosis within the pulmonary parenchyma, would appear on x-ray. (DX 30).<sup>5</sup>

Dr. Richard L. Naeye, who is board-certified in anatomic and clinical pathology (EX 5, p. 4), issued a report, dated August 29, 1998, which referred to some medical evidence, but primarily focused on his analysis of the tissue samples. He noted that of the 29 glass slides, 9 were slides of the lung tissue (DX 30). Dr. Naeye stated, in pertinent part:

All of the lung sections contain lesions that range from 0.2 to 8 mm in diameter. They are comprised mainly of old, partially hyalinzed collagen with varying sized rims of black pigment, particularly all those sites w[h]ere the most black pigment is present. The lesions that are 1-7 mm in diameter are anthracotic micronodules with a partially silicotic origin. The largest lesion present is 16 mm in its largest dimension. It is not a single lesion but rather is comprised of several confluent anthracotic micro and macronodules...

Dr. Naeye also noted the presence of moderately severe centrilobular emphysema, focal emphysema in halos around the anthracotic lesions consisting of about five percent of the emphysema in the lung sections, evidence of chronic bronchitis, pneumonia, and squamous cell carcinoma.

INTERPRETATION: ...Simple CWP was present. Microscopically it was very severe but this cannot be taken at face value without knowing the results of pulmonary function studies because the tissues removed for microscopic examination may or may not have been representative of the lungs as a whole. Mr. Whittington had normal or almost normal results of pulmonary function studies in 1986 and 1994. Thus he was not disabled by pulmonary problems when he retired in 1991. He had back problems and complained that dusty conditions interfered with his work at that time. It is very well documented that simple CWP does not advance after a worker quits mining coal so there is no basis for postulating that this man's CWP produced any disability or contributed in any way to hastening his death. [citations to medical literature omitted].

(DX 30).

Dr. Naeye reiterated much of the substance of the foregoing conclusions in his testimony on deposition on April 1, 1999. He testified that he "got a relatively generous number of slides," a "good sample," with "a lot of variation in the disease processes from one slide to another," and "all of the slides had multiple anthracotic micronodules as well as macules" and "five of the slides had one or more macronodules in addition. And, of course, there were macules on top of all that." He noted that "some of the lesions were very old and the larger lesions, the core of the lesions were comprised of hyalinized collagen and black pigment was on the periphery. So those are lesions that went back many years before [the Miner] died." Significantly, Dr. Naeye testified, "The location of the lesions was the usual location, namely adjacent to small arteries and airways. There w[ere] areas of interstitial fibrosis and one area of massive fibrosis. And those latter lesions are not part of the coal workers pneumoconiosis and there weren't many such lesions in the lungs. I know that from having reviewed the results of the chest x-rays." (EX 5 at 9-10, 22)

<sup>&</sup>lt;sup>5</sup>Dr. Plata listed "Bilateral multifocal acute bronchopneumonia" as the cause of death (DX 30).

Dr. Naeye categorized the coal workers' pneumoconiosis present as either moderately severe or severe simple coal workers pneumoconiosis based on just the tissue analysis, but moderately severe based on chest x-rays. (EX 5 at 9-10, 22) Dr. Naeye testified categorically that the Miner did not have a totally disabling respiratory impairment prior to his death because there was only mild deterioration in the results of the pulmonary function studies and arterial blood gas analyses over a period of years. (EX 5 at 12-13) Dr. Naeye also opined "that overall the [very, very heavy] cigarette smoking did not cause significant impairments in lung function and therefore contribute to his death," but he also opined that the smoking had caused substantial heart damage which contributed to the Miner's death. (EX 5 at 14-15)

With respect to the heart damage, Dr. Naeye declared that "the right ventricular wall also was increased in thickness [in addition to the very, very thick left ventricular wall in his heart]. And so there was chronic cor pulmonale" which was due to a combination of factors, so that "the chronic heart failure and all the heart damage he had led to a secondary change in the right side of the heart and that was probably the major factor" which could have caused the Miner's shortness of breath. EX 5 at 16-17) Dr. Naeye opined that the moderate or severe coal workers pneumoconiosis would not have had "zero cause" of the symptoms such as shortness of breath, coughing, and the like, but "it's such a minor cause you can't quantitate [sic] it." Dr. Naeye opined categorically that the Miner's pneumoconiosis did not have "any role at all" in the Miner's disability or death. (EX 5 at 17) Dr. Naeye also declared that because he had access to the pulmonary function studies and other analyses of the Miner's lung function, it would not have been helpful to have seen the Miner's body in gross examination. (EX 5 at 23)

Dr. Naeye explained that the Miner did not have complicated pneumoconiosis because the clinical history was not characteristic of complicated pneumoconiosis, which tends to be accompanied by a rapid or semi-rapid downhill course in terms of lung function, which the Miner did not have. (EX 5 at 18-19) Dr. Naeye characterized the areas of fibrosis ranging from a few millimeters up to large masses described by Dr. Plata in the autopsy protocol as "almost certainly due to an old area of organized pneumonia" which did not look like the lesions produced by occupational exposure to coal mine dust or those called progressive massive fibrosis. Dr. Naeye described progressive massive fibrosis as some kind of an immunologic disorder that arises mainly in coal workers who have moderate or severe simple coal workers pneumoconiosis, and which has distinctive microscopic features. "The centers are ... sometimes ...liquid. If they're not liquid, they're dense hyalinized collagen" and have certain other distinctive features. Dr. Naeye reiterated that the only area of massive fibrosis he found was "clearly the result of almost surely some infection this man had at some time..." which reflected a rare type of scar which happens once in fifty or a hundred times. (EX 5 at 9-10, 20-21)

Dr. Naeye testified that there were several kinds of fibrosis in the Miner's lungs. The anthracotic macules and micronodules and a few macronodules tended to have fibrosis related to the Miner's occupational exposure. But some areas of interstitial fibrosis were not so caused. Dr. Naeye suggested that the large lesions which produce a one centimeter diameter lesion on an x-ray should be two centimeters in actual diameter in the lungs, "which should be the diagnostic threshold for diagnosing complicated coal workers pneumoconiosis." (EX 5 at 21-22) Dr. Naeye also testified that the largest lesion he could find was 16 millimeters in greatest diameter, but that it was not the typical lesion caused by progressive massive fibrosis. Rather it was what he would call "a consolidated lesion in which several smaller lesions had come together and were together...so you would see distinctive patterns of multiple lesions in this 16 millimeter lesion" which would distinguish it from the disease known as [progressive massive fibrosis]. EX 5 at 23-24)

Dr. Jerome Kleinerman, who is board-certified in pathologic anatomy and clinical pathology, issued a report dated November 6, 1998, which included a summary of available medical evidence and

an analysis of tissue slides. Inexplicably, Dr. Kleinerman cited a total of 31 histologic slides, 18 sections of lung tissue mounted on 11 slides, although Dr. Naeye referred to 29 slides, 9 of lung tissue, in his August 29,1998, report. (EX 1; DX 30). In pertinent part, Dr. Kleinerman opined:

...The vast majority of the (lung) sections show nodular lesions of simple silicosis; the nodules vary in size from 3-9 mm. In two sections there is evidence of nodular lesions adjacent to one another forming irregular nodular conglomerate lesions. The lesions however are discrete and appear separable and are therefore <u>not</u> complicated silicotic lesions. The central areas of several nodules are undergoing ischemic necrosis are cavitated centrally. Other lung sections show typical lesions of simple CWP. The macules of simple CWP are fewer in number than are the silicotic nodules. Focal areas of nonspecific interstitial fibrosis are present adjacent to some lesions of simple silicosis and in the subpleural lung tissue, particularly at the apex...Three sections of what appear to be hilar lymph nodes show large areas of lymphoid parenchyma replaced by pigmented and hyalinized fibrosis...

Having recited the evidence which formed the basis for his opinion, but without explicit reasoning or analysis, Dr. Kleinerman opined that the Miner's lung tissue showed evidence of a moderate extent of simple nodular silicosis and a small extent of simple coal workers' pneumoconiosis. But he declared that since he had not reviewed pulmonary function studies and/or arterial blood gas values, he could not determine if the Miner had pulmonary or respiratory impairment, or to what extent the pneumoconiosis caused or contributed to any pulmonary impairment. Dr. Kleinerman opined that the Miner did suffer from a reduced capacity to perform his usual coal mine work as indicated by the medical records of his hospital admissions in November 1993, September 1997, and November 1997, and prior to his death, but the doctor could not evaluate the extent of the disability due to coal mine dust and/or other factors because the serial pulmonary function and arterial blood gases which were apparently performed, and referred to in Dr. Naeye's report, were not submitted for his review. (EX 1).

In a supplemental report dated December 5, 1998, however, Dr. Kleinerman reviewed additional medical data including the pulmonary function studies and arterial blood gas values obtained before, and in 1994, three years after, the Miner retired from coal mine work. He opined that the moderate degree of simple nodular silicosis and mild degree of simple CWP present in the Miner's lungs at autopsy did not contribute to and did not hasten his death. He opined that the pulmonary function and arterial blood gas values before and after retirement indicated that the Miner did not have a reduced capacity to perform his coal mine work either before or after his retirement. He opined that the lung cancer was not likely to have produced impairment of respiratory function, and that the chronic bronchitis, interstitial fibrosis, and pulmonary thromboemboli demonstrated at autopsy were not caused by the simple nodular silicosis or simple CWP or exposure to coal mine dust. He opined that the nodular lesions of simple silicosis and simple CWP are not complicated CWP, because the nodular lesions are discrete and separable and are conglomerate but do not have the tissue characteristics of complicated CWP. He declared that his opinion was based on recent evidence obtained from study of chest x-rays of working and recently retired coal miners which, despite the premise that coal workers' pneumoconiosis is an incurable progressive disease, purportedly demonstrates that simple CWP and simple nodular silicosis do not progress after a miner leaves the exposure to coal mine dust. (EX 2).

Dr. Shawn A. Chillag, who is board-certified in internal medicine and geriatrics, issued a supplemental report, dated January 11, 1999, in which he reviewed available medical data and concluded that there was sufficient objective pathologic and radiographic evidence to justify a diagnosis of simple coal worker's pneumoconiosis, but that the miner did not suffer any pulmonary impairment or reduced pulmonary capacity to perform his coal mining work prior to his terminal

acute illness. Dr. Chillag opined that the Miner's pulmonary function was reduced because of factors such as obesity, pneumonia, pulmonary embolism and prior surgeries, and that coal dust exposure did not play any role in that disability prior to his death. Dr. Chillag opined that the acute terminal illness was unrelated to pneumoconiosis or the Miner's coal mine employment. (EX 3).

Dr. James R. Castle, a B-reader who is board-certified in internal medicine and pulmonary disease, issued a supplemental report dated January 20, 1999, in which he opined that any respiratory impairment from which the Miner suffered immediately prior to his death was not the result of the underlying simple coal workers' pneumoconiosis that was present, and that none of the objective data present indicate that there was a reduced capacity to perform his coal mine employment prior to his death from a respiratory or pulmonary standpoint. Dr. Castle opined that the requirement for oxygen therapy was not due to the Miner's simple coal workers' pneumoconiosis, but that it was far more likely related to his underlying severe cardiac disease and tobacco smoke induced lung disease. Dr. Castle opined that as a whole man the Miner did suffer from a reduced capacity to perform his usual coal mining employment duties prior to his death, but that this reduction was related to coronary artery disease, diabetes mellitus, and possible tobacco smoke induced chronic obstructive pulmonary disease. He opined that coal workers' pneumoconiosis did not play any role in any disability and played no role in, and did not hasten the Miner's death. (EX 4).

Dr. Robert J. Crisalli, who is board-certified in internal medicine and pulmonary diseases, testified on deposition on June 2, 1999, that he had examined the Miner in 1994, when he was "on call" for Dr. D'Brot, and that, although he did not specifically recall his discussion with Laura Whittington at the hospital, he did not think her recollection was entirely accurate. He acknowledged that, if such a discussion had occurred, a positive x-ray might have caused him to inquire whether the Miner knew if he had pneumoconiosis, and that the inquiry might have been misinterpreted. (EX 6, at 3, 6, 23-25). Although Dr. Crisalli did not personally examine the histologic slides, he adopted the conclusions of Drs. Naeye and/or Kleinerman that there were distinct lesions consistent with simple, not complicated, pneumoconiosis (EX 6, at 39-40).

Based upon his review of the available medical evidence, Dr. Crisalli concluded that the miner did not have complicated pneumoconiosis or progressive massive fibrosis; that he had developed an impairment due to a combination of cardiac and respiratory factors, primarily the former, prior to his death; but that there were insufficient data to determine whether the impairment was totally disabling. Dr. Crisalli opined that pneumoconiosis played no role in the miner's disability or death (EX 6, at 36-37). In a report dated September 14, 1997, attached to Dr. Crisalli's deposition, Dr. Miller, the cardiac consultant, diagnosed hypotension secondary to severe shock. Although he did not specifically list pneumoconiosis, he opined that the ECG results were "compatible with severe COPD cor pulmonale" (EX 6, Deposition Exhibit 1).

Dr. Juan M. D'Brot, who is board-certified in internal medicine, pulmonary disease, and critical care, treated the Claimant for several years prior to the miner's death (CX 2, at 2-3).<sup>7</sup> In his

<sup>&</sup>lt;sup>6</sup>In a report dated September 19, 1994, Dr. Chillag had diagnosed coal workers' pneumoconiosis, but no pulmonary impairment, and permanent total disability due to other specified causes. (DX 30)

<sup>&</sup>lt;sup>7</sup>In his curriculum vitae Dr. D'Brot identified only "Pulmonary Medicare" and "Critical Care Medicare" under his Specialty and Subspecialty Certification. However, I take judicial notice that his relevant qualifications are listed on the worldwide web, American Board of Medical Specialties Public Education Program, Verification of Certification Results, at

March 26, 1999, testimony on deposition, Dr. D'Brot stated that he began treating the Claimant regularly in 1993 for multiple conditions, including chronic obstructive pulmonary disease, pneumoconiosis, diabetes mellitus, obstructive sleep apnea, and depression (CX 2, at 6-7). Dr. D'Brot continued to treat the Miner until his death on November 21, 1997, when Dr. D'Brot completed the death certificate which identified the cause of death as respiratory failure due to pulmonary fibrosis due to coal workers' pneumoconiosis (CX 2, p. 8; DX 30).

Dr. D'Brot stated that the Claimant's breathing deteriorated over the years, and declared categorically that the Claimant's pulmonary function impairment got much worse between Dr. Crisalli's examination in 1994, which indicated by the pulmonary function test that the miner did not have a pulmonary impairment, and the miner's death, when Dr. D'Brot opined that the autopsy established the existence of the respiratory impairment. (CX 2 at 34) With respect to the "walk test," he noted that the Claimant was already getting oxygen because his PO2 and his 02 saturation were extremely low, and related these abnormalities to progressive pulmonary fibrosis due to coal mine dust exposure. He testified that the progressive pulmonary fibrosis developed "a couple of years before his demise" due to "whatever occupational exposure that he had in the mines...Coal dust or silicon, or who knows what" and led to extremely low oxygen saturation. (CX 2, p. 11-14). Dr. D'Brot could not pinpoint when the diagnosis of progressive pulmonary fibrosis was first justified, but stated that chest x-rays and symptomatology indicated that the condition had been "building up" since 1993, or perhaps earlier, and was unrelated to smoking. Dr. D'Brot testified that he was not surprised by the autopsy finding of complicated pneumoconiosis, and that he had begun mentioning that as a possible diagnosis in 1996 (CX 2, at 11-16). Dr. D'Brot acknowledged that many of the results of clinical tests in 1994 were essentially normal, and that his diagnosis of COPD was based primarily upon Claimant's long smoking history and respiratory complaints. Nevertheless, he insisted that the Claimant had complicated coal workers' pneumoconiosis, although he admitted that it would be very unusual for a person with significant lung disease and significant pulmonary fibrosis, to have essentially normal objective data. (CX 2, at 21-34)

The exhibits attached to Dr. D'Brot's deposition include reports dated April 18, 1997, and September 29, 1997, diagnosing progressive pulmonary fibrosis due to occupational pneumoconiosis and total disability therefrom (CX 2, Exhibits 2-3); office notes dated September 9, 1997, which include diagnoses of end stage lung disease and a history of pulmonary embolism (CX 2, Exhibit 4); a hospital discharge summary dated September 24, 1997, listing various discharge diagnoses, including end-stage chronic obstructive pulmonary disease, hypotension, congestive heart failure, diabetes, coal workers pneumoconiosis, and coronary artery disease, status post coronary artery bypass grafting (CX 2, Exhibit 5)<sup>8</sup>; various handwritten office notes (CX 2, Exhibit 6); a typewritten office note, dated November 12, 1997, recording a diagnosis of progressive pulmonary fibrosis/rule out bronchitis with organizing pneumonia (CX 2, Exhibit 7); a nonconforming November 12, 1997, chest x-ray reading by Dr. Willis of stable diffuse fibrosis (CX 2, Exhibit 8); a "History and Physical Examination" report dated November 17, 1997, reflecting a physical examination noting diffuse expiratory wheezes throughout all lung fields, and stating that the miner was admitted at Charleston Area Medical Center for shortness of breath, and that the Miner "sleeps in a recliner, but has had to sit up further in the past three days to breath[e]." Dr. D'Brot diagnosed chronic obstructive pulmonary disease, congestive heart failure, insulin dependent diabetes mellitus, and disorientation (CX 2, Exhibit 9).

www.certifieddoctor.com. See Maddaleni v. Pittsburgh & Midway Coal Mining Co., 14 BLR 1-135 (1990).

<sup>&</sup>lt;sup>8</sup>The discharge summary, dated September 24, 1997, includes the following arterial blood gas study results: pCO2-41 and pO2-46, "and that was on a 50% Venitmask." (CX 2, Exhibit 5).

The attached "Death Summary" dated November 21, 1997, listed the final diagnoses as end-stage chronic obstructive pulmonary disease, acute infarction of right occipital area and small infarction in the right frontal region, congestive heart failure, insulin-dependent diabetes mellitus, and disorientation and hallucinations (CX 2, Exhibit 10). A pulmonary function study dated January 5, 1994, was interpreted as indicating normal airflow studies, markedly reduced diffusing capacity, and slightly decreased lung volumes "suggestive of early interstitial lung disease or pulmonary vascular disease" (CX 2, Exhibit 11). A radiology report dated February 18, 1994, reflecting a CT scan of the abdomen is immaterial except for a notation of marked interstitial thickening noted in the visualized portion of the lung bases bilaterally, and an April 28, 1995, radiology report of PA and Lateral chest x-ray noted extensive reticulonodular interstitial changes in the lung fields bilaterally with an appearance most consistent with pneumoconiosis, but with clinical correlation required. The report also noted bilateral pleural thickening, and flattening of the hemidiaphragms bilaterally and increased AP diameter suggesting emphysematous changes. (CX 2, Exhibit 12-13).

# **Discussion and Analysis**

## Modification: Change in Conditions or Mistake of Fact

Claimant's request for modification is governed by \$725.310 of the regulations, which provides that any party may request modification of an award or denial of benefits on grounds of a change in conditions or because of a mistake in a determination of fact, if such request is filed within one year after the denial of a claim or last payment of benefits. Where a mistake in a determination of fact is the grounds for the modification request, new evidence is not a prerequisite, and a mistake of fact may be corrected, whether demonstrated by new evidence, cumulative evidence, or further reflection on evidence initially submitted. *Kovac v. BCNR Mining Corporation*, 16 BLR 1071 (1992), *modifying* 14 BLR 1-156 (1990). In determining whether the miner has established a change in conditions, the administrative law judge must conduct an independent assessment of the newly submitted relevant evidence, in conjunction with the evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish an element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 BLR 1-111 (1993). The instant case involves a purported mistake in a determination of fact or change in conditions derived from the death of the Miner and new evidence generated by an autopsy and responses thereto.

Because simple pneumoconiosis has been previously established before Judge Neusner, and because Employer has conceded that the miner had simple pneumoconiosis arising from his 43 years of coal mine employment, both entitlement to modification and entitlement to benefits depend upon whether Claimant has established complicated pneumoconiosis pursuant to \$718.304, or total disability due to pneumoconiosis pursuant to \$718.204(b) and (c) as elements essential to proof of a change in conditions or a mistake in a determination of fact pursuant to \$725.310, as well as entitlement on the merits. All categories of the relevant evidence of record must be considered and weighed together under \$718.304(a), (b), and (c), in order to invoke the irrebuttable presumption of

<sup>&</sup>lt;sup>9</sup>The Death Summary, dated November 21, 1997, includes the results of chest x-ray, arterial blood gas study, and EKG. The x-ray "showed a right pleural effusion and patchy infiltrates, right greater than left, and questionable pulmonary edema per radiologist." The blood gas values were: pCO2, 29, and pO2, 89. However, the report notes that the miner was "on unknown amount of oxygen." Finally, the "EKG showed sinus rhythm with a right bundle branch block and nonspecific ST T-wave changes." (CX 2, Exhibit 10).

total disability due to pneumoconiosis, total disability due to pneumoconiosis at the time of death, or death due to pneumoconiosis based on proof of complicated pneumoconiosis. *See Melnick v. Consolidation Coal Co.*, 16 BLR 1-31 (1991)(*en banc*).

The irrebuttable presumption of total disability due to pneumoconiosis under §718.304 may be invoked in this case if the Miner is proved to have suffered from a chronic dust disease of the lung which, (a) when diagnosed by chest x-ray, yields one or more large opacities greater than one centimeter in diameter and would be classified in Category A, B, or C in the ILO-U/C International Classification of Radiographs; or (b) when diagnosed by autopsy, yields massive lesions in the lung; or (c) when diagnosed by other means in accordance with acceptable medical procedures, could reasonably be expected to yield such results. Invocation of the irrebuttable presumption requires proof that the miner has a chronic disease of the lung commonly known as complicated pneumoconiosis, and consideration of all relevant evidence to that end. Lester v. Director, OWCP, 993 F.2d 1143, 17 BLR 2-114 (4th Cir. 1993). Complicated pneumoconiosis is not restricted to a purely medical definition. See Eastern Associated Coal Corp. v. Director, OWCP [Scarbro], 220 F3d 250, 2000 WL 961592 (4th Cir. 2000). In construing the requirements of §718.304, which identifies three different ways of diagnosing complicated pneumoconiosis, the Administrative Law Judge must perform equivalency determinations to insure that the same underlying condition which invokes the presumption by producing opacities greater than one centimeter in diameter on an x-ray would be considered "massive lesions" under the statute and regulations if diagnosed through biopsy or autopsy. See Double D Mining, Inc. v. Blankenship, 117 F.3d 240 (4th Cir. 1999). "Massive," which is not defined in the statute or regulations is used in the ordinary sense and not as a term of art. See Scarbro. Although it has been suggested that "massive lesions" diagnosed by biopsy would need to be at least two centimeters in size in order to appear as one centimeter in size by x-ray, the statute requires only that, if diagnosis is by biopsy or autopsy, that the "massive lesions" would show on an x-ray of opacities of at least one centimeter. Such a conclusion requires an equivalency determination in each instance by the Administrative Law Judge. See Id.

The autopsy evidence in the context of the medical evidence as a whole proves the existence of substantial and pervasive lesions and at least one large lesion greater than one centimeter which might be classified as Category A and related to the Miner's exposure to coal mine dust. *See Handy v. Director, OWCP*, 16 BLR 1-73 (1990). This evidence could be deemed to establish "massive lesions in the lung" under the regulation, if the necessary equivalency determination could be made, and thus to establish the existence of complicated pneumoconiosis. The applicable regulations make the references by the opining doctors to the results of pulmonary function and arterial blood gas studies and conglomerate lesions with separable nodules immaterial to the determination. It is settled law that "pulmonary function studies are not relevant to a determination under Section 718.304(c) since such studies are relevant only to the issue of disability and not the existence of pneumoconiosis." *See Trent v. Director, OWCP*, 11 BLR 1-26, 1-28 (1987). Although there is additional and substantial diverse evidence of record relating to the Miner's condition, in contrast to

<sup>&</sup>lt;sup>10</sup>In the absence of any more particular definition in the Act or regulations, and consistent with the commonly understood meanings of the word, the term "lesion," is defined in *Dorland's Pocket Medical Dictionary* (23d ed.) as "any pathological or traumatic discontinuity of tissue or loss of function of a part." The most applicable definitions of "massive" in *Webster's Ninth New Collegiate Dictionary* are at "2c(1): large in comparison to what is typical [massive dose of penicillin] (2): being extensive and severe [massive hemorrhage][massive collapse of a lung]." *See Scarbro*.

the record before Judge Neusner, the only x-ray evidence of complicated pneumoconiosis is still Dr. Bassali's reading of the July 21, 1993, x-ray.

Having reviewed the x-ray evidence, I find that the preponderance of such evidence, including those interpretations by dually qualified B-readers and board-certified radiologists, is positive for advanced simple, but not complicated, pneumoconiosis. Dr. Bassali and Dr. Francke, who are both B-readers and board-certified radiologists, reading the x-rays dated July 21, 1993, and November 3, 1993, respectively, initially found complicated pneumoconiosis, Category A, by x-ray under \$718.304(a), as well as advanced simple pneumoconiosis, classification 3/2 r/r by Dr. Bassali and 2/2 r/q by Dr. Francke. (DX 30) Drs. Wiot, Shipley, and Spitz, board-certified radiologists and Breaders, as well as other doctors similarly qualified, also interpreted the x-rays in most cases as classification 2/2 r/q. (DX 21, 30) However, Dr. Francke reread the November 3, 1993 film on October 4, 1994, in conjunction with x-rays dated April 26, 1979, and March 9, 1994. omitting the complicated pneumoconiosis classification, and thus changing his opinion, but without explanation. (DX 30) The interpretation by Dr. Bassali, who is a board-certified radiologist and B-reader, which provides evidence of a large opacity of complicated pneumoconiosis, Category A, consistent with the prosector's findings of complicated pneumoconiosis based on the autopsy evidence, a finding of complicated pneumoconiosis, with a large Category A opacity, is not enough, when weighed against the contrary x-ray interpretations by comparably qualified readers, to support a finding of complicated pneumoconiosis on the basis of the x-ray evidence.

Having weighed the conflicting pathology interpretations, I accord more weight to the findings of the prosector, Dr. Plata, than the contrary opinions by Drs. Naeye and Kleinerman, because of the comprehensiveness and detail of the prosector's observations, and because of the conflicts, circumscriptions, and equivocations in the opinions of Drs. Naeye and Kleinerman. See, Scarbro; Gruller v. Bethenergy Mines, Inc., 16 BLR 1-3 (1991); Similia v. Bethlehem Mines Corp., 7 BLR 1-221 (1979). However, Dr. Plata's findings, including that of complicated pneumoconiosis, provide no basis for the equivalency determination required by Scarbro that would equate any of those findings on autopsy with one or more large opacities of one centimeter or more on x-ray. Dr. Plata's credible findings of pervasive changes in both lungs described as consisting, inter alia, of extensive black pigmentation of the pleural surface with areas of scarring and retraction, scattered coal macules more than .3 cm in greatest dimension, larger black nodules up to .8 cm, scattered blackened scars up to 6 cm, the ill defined cancerous lesion in the right upper lobe approximately 2 cm. in diameter and surrounded by scarring and black pigmentation, relatively severe pulmonary emphysema, black pigmentation associated with fibrosis varying from a few millimeters up to large masses in size on the pleural surfaces, on and within the pulmonary parenchyma, and hilar lymph nodes, and mediastinal and hilar lymph nodes showing extensive anthracotic silicotic nodules, reflect an extensive and detailed examination and findings of massive lesions in the ordinary sense. However, even considered with the corroborative detailed descriptions of the tissue slides as examined by Drs. Naeye and Kleinerman, including the identification of the conglomerate or confluent lesion or opacity measuring 1.6 cm., Dr. Plata's findings do not establish the existence of "massive lesions" as contemplated by the applicable regulations under the rubric of *Scarbro*.

The facts in this case are remarkably similar to those in *Scarbro*, except that the x-ray evidence of large opacities which existed in *Scarbro* is lacking in this case, except for Dr. Bassali's single x-ray interpretation. Both Dr. Naeye and Dr. Kleinerman were consulting pathologists in *Scarbro*, and their opinions in that case bear a striking resemblance to their opinions in this case. Since they are similarly qualified, and reviewed the same slides, it is odd that Dr. Naeye assessed moderately severe to severe coal workers pneumoconiosis, while Dr. Kleinerman assessed mild coal workers' pneumoconiosis. Dr. Plata conducted the autopsy in November 1997. Dr. Naeye did not review all of the slides in August 1998. In November 1998, Dr. Kleinerman apparently examined a group of slides which included the missing slides. Dr. Naeye testified that he actually received the

case twice and suggested that he reviewed 11 lung slides on one of those occasions. When asked at deposition about the disparity in the number of slides, Dr. Naeye did not satisfactorily explain what happened to the two missing slides, nor when or how he recovered them. He simply testified: "I'm afraid that something happened to two slides in the interim." (EX 5, 22) Significantly, Dr. Naeye initially stated that he only reviewed 29 slides, 9 of which were lung slides (DX 30). Subsequently, he testified that "there were 11 slides with lung tissue." (EX 5, p. 6). Dr. Kleinerman reported that he reviewed 31 slides, of which 11 were lung slides containing 18 sections of lung. The discrepancy is not resolved.

Dr. Naeye's opinion is ambiguous in that he refers to the "largest lesion" as being 16 mm, which could qualify under §718.304(a), but which he described as comprised of several confluent micro and macronodules. Dr. Naeye conceded that there is one area of massive fibrosis. However, he stated equivocally that it was "almost surely some infection." (EX 5, at 20-21). Dr. Naeye's measurements of the lesions or micronodules preserved in the slides measured up to 7 or 8 mm. in diameter. Dr. Kleinerman opined that the nodules on the slides vary in size from 3-9 mm, just shy of the qualifying size for complicated pneumoconiosis, and that in two sections there is evidence of nodular lesions adjacent to one another forming irregular nodular conglomerate lesions which, however, he declared are "discrete and appear separable and "are therefore not complicated silicotic However, he, like Dr. Naeye, did not satisfactorily explain his categorical conclusion. Furthermore, neither Dr. Naeye nor Dr. Kleinerman established that the tissue samples which they received were representative of the Miner's total lung condition and had been properly prepared and stored, which has an impact upon their value as valid samples. See McLaughlin v. Jones Laughlin Steel Corp., 2 BLR 1-103, 1-109 (1979). Indeed, in addition to being unable to account for the missing slides, Dr. Naeye declared that he could not be sure that the tissue samples were reliably representative. But this declaration conflicts with the logical inference from his express characterization that he got a "good sample" from a "relatively generous number of slides" reflecting "a lot of variation in the disease processes," and did not need to see the Miner's body since he had the slides. The apparent difference is unexplained, but puts the accuracy of the two experts' measurements, and thus opinions, in doubt in critical respects.

Also, Dr. Naeye did not explain satisfactorily why the described condition does not qualify as a large opacity in excess of one centimeter in size or as an indication of massive fibrosis or lesions in the lung qualifying as complicated pneumoconiosis under §718.304, as opposed to an apparently technical clinical medical definition. He testified in his deposition that "progressive massive fibrosis" has distinctive microscopic features, with centers sometime liquid, or, if not liquid, dense hyalinized collogen. He described some of the old and larger lesions he observed on the slides had cores comprised of hyalinized collagen and black pigment on the periphery. He did not explain why the lesions would not have qualified, therefore, as progressive massive fibrosis, especially when he observed "massive fibrosis." In addition, his suggestion that a one centimeter opacity on x-ray should reflect a two centimeter lesion on autopsy to qualify as complicated pneumoconiosis is inconsistent with applicable law. See Handy v. Director, OWCP, 16 BLR 1-73 (1990)

In addition, Dr. Naeye did not satisfactorily explain why the old and larger lesions with hyalinized collagen cores did not qualify as progressive massive fibrosis, which he described as typically having centers of dense hyalinized collagen. Thus, despite the credentials of Drs. Naeye and Kleinerman, and their review of medical evidence other than the histologic slides, I find that the opinion of the prosector, Dr. Plata, is entitled to the greatest weight because of its comprehensiveness, consistency, and detail of his first hand examination and analysis of the Miner's respiratory system. *See Scarbro*. Therefore, I find that the Claimant has proved the existence of complicated pneumoconiosis under §718.304(b), and that the evidence under §718.304(a) and (c) does not impeach that conclusion, especially given the inherent reliability of autopsy evidence in relation to other types of evidence..

Although most of the pulmonary specialists, such as Drs. Chillag, Castle, and Crisalli, found simple pneumoconiosis rather than complicated pneumoconiosis, Dr. D'Brot, who was the miner's longstanding treating physician, diagnosed complicated pneumoconiosis based on extensive observation. Moreover, Drs. Chillag, Castle, and Crisalli relied, in significant part, on the pathology findings which supported their respective positions regarding the presence or absence of complicated pneumoconiosis. Thus, they found the opinions of Drs. Naeye and Kleinerman persuasive, whereas Dr. D'Brot credited the opinion of Dr. Plata, the prosector. Drs. Chillag, Castle, and Crisalli cited the near normal pulmonary function studies and arterial blood gases in 1994 as part of their basis for finding that the Claimant did not have complicated pneumoconiosis. But, as previously noted, those studies are not material to a determination of the existence of the disease. *See Trent v. Director, OWCP, supra*. Moreover, reliance on those test results did not take account of the Miner's rapid deterioration thereafter as described, which was relied upon, by Dr. D'Brot in making his assessment. Dr. Naeye observed that complicated pneumoconiosis tends to be accompanied by a rapid or semirapid downhill course in terms of lung function.

Dr. D'Brot conceded that it is unusual for a person to have complicated pneumoconiosis without manifesting a significant respiratory impairment, and he acknowledged that the clinical studies in 1994 did not reveal a disabling respiratory or pulmonary impairment. However, he stated that the miner's respiratory and pulmonary condition substantially worsened in the years immediately preceding his death. In addition, the record contains the earlier opinions of Drs. Rasmussen based on examinations in 1977 and 1993, Gaziano in 1979, Crisalli in 1994, Chillag based on a review of medical records in 1994, and Castle based on medical records in 1994, which have little probative value because of their age, the fact that the autopsy and related evidence was not available to them, the credible evidence that the Miner's condition severely deteriorated after 1994, and the consensus of the more recent opinions that the Miner was totally disabled at the time of death. (DX 30). Likewise, the December 13, 1997, consultant report by Dr. Ranavaya, who opined that Dr. D'Brot's "walk test" was worthless as a determinant of disability from pulmonary pathology or the existence of coal workers' pneumoconiosis, is essentially immaterial.

Because the x-ray evidence is conflicting, although there is consensus on the advanced stage of the disease, and because Dr. Bassali, qualified both as a B-reader and a board-certified radiologist found complicated pneumoconiosis, Category A, I find that the x-ray evidence does not preclude the existence of complicated pneumoconiosis, Category A, in light of the other evidence of record. Section 718.202(b) prohibits the denial of a claim solely on the basis of a negative x-ray. Moreover, it is well settled that autopsy evidence is more probative than x-ray evidence in in establishing the existence of of pneumoconiosis. *See Terlip v. Director, OWCP*, 8 BLR 1-363 (1985). Although a majority of physicians found only advanced simple pneumoconiosis, Dr. D'Brot, Claimant's long-term treating physician, diagnosed complicated pneumoconiosis, which was the physician's opinion most consistent with the autopsy findings of the prosector, whose report is well-documented and well reasoned. The opinion of a treating physician, because of his status as treating physician, is entitled to great, although not necessarily dispositive, weight. *See Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1097, 17 BLR 2-123 (4th Cir. 1993); *Hubbard v. Califano*, 582 F.2d 319 (4th Cir. 1978)

Greater weight may be accorded to the opinion of a physician who performs the autopsy than that of a physician who reviews the autopsy slides, and such weight is justified by the reasoning in Dr. Plata's protocol. *See Gruller v. Bethenergy Mines, Inc.*, 16 BLR 1-3 (1991); *Similia v. Bethlehem Mines Corp.*, 7 BLR 1-535 (1984); *Cantrell v. U.S. Steel Corp.*, 6 BLR 1-1003 (1984) For these reasons Dr. Plata's evaluation and opinion is given greater weight than the circumscribed and unsatisfactorily explained opinions of the other pathologists, Drs. Naeye and Kleinerman. In view of the foregoing, I find that the Claimant has established the presence of complicated pneumoconiosis under §718.304. Drs. D'Brot and Plata found complicated pneumoconiosis and related the disease to Claimant's coal mine employment or described it as "Complicated Coal Workers' Pneumoconiosis"

(CX 2; DX 30) Employer has not rebutted the presumption that the Claimant's pneumoconiosis arose from his approximately 43 years of coal mine employment. §718.203. Therefore, I find that the Claimant is entitled to invoke the irrebuttable presumption that he was totally disabled due to pneumoconiosis.<sup>11</sup>

There is also substantial medical evidence of record which I find establishes the existence of cor pulmonale with right sided congestive heart failure and thus total disability of the Miner under §718.204(c)(3). Dr. Naeye noted that the right ventricular wall was increased in thickness so that there was chronic cor pulmonale due to a variety of factors, so that the chronic heart failure and heart damage had led to a secondary change in the right side of the heart. This would seem to suggest right ventricular failure. The report by Dr. Miller, the cardiac consultant, dated September 14, 1997, which was attached to Dr. Crisalli's deposition, contained the doctor's opinion that the ECG results were compatible with severe COPD cor pulmonale. Dr. D'Brot's various reports over time contain repeated assessments of congestive heart failure, though he never expressly specified that it was right sided. There is no contradiction of any of this evidence related to the existence of cor pulmonale, congestive heart failure, or Dr. Naeye's reference to the right ventricular heart disease. Cor pulmonary has been recognized as heart disease due to hypertension secondary to disease of the blood vessels of the lungs. See Newell v. Freeman United Coal Mining Co., 13 BLR 1-37 (1989). There is abundant evidence of severe lung disease related to coal mining from the autopsy and otherwise. Dr. D'Brot's opinion as the long term treating physician establishes a persuasive causal relation between this condition and coal mine dust exposure or coal workers' pneumoconiosis. Taken together, this evidence is deemed to establish total disability which is due at least in part to coal workers' pneumoconiosis, and thus to establish an alternative basis for entitlement of this Claimant to black lung benefits. See Newell v. Freeman United Coal Mining Co., supra..

## Period of Entitlement

Since the first diagnosis of complicated pneumoconiosis is attributable to Dr. Bassali's x-ray reading of a film dated June 21, 1993, I find that the date of onset of total disability due to pneumoconiosis is June 1, 1993. *See Truitt v. North American Coal Corp.*, 2 BLR 1-199, 1-203-204 (1979). However, since the Claimant died on November 21, 1997, his entitlement to benefits ceased in October 1997, the month before the month during which he died. §725.203(b)(1). Payments

<sup>&</sup>lt;sup>11</sup>The record includes evidence which supports Dr. D'Brot's finding of total disability, including a nonconforming but qualifying arterial blood gas test dated September 24, 1997 during a hospital admission for acute shortness of breath (CX 2, Exhibit 5); and findings of cor pulmonale, hypertrophied muscle fibers in the heart, increased thickness of the right ventricular wall, as well as the left, causing chronic cor pulmonale due to a combination of factors, apparently with right-sided congestive heart failure, and right bundle branch block. Dr. Naeye testified, with reference to the Miner's cor pulmonale, that the chronic heart failure and the Miner's heart damage led to a secondary change in the right side of the heart, which would have been a major factor with respect to the Miner's breathing problems between his last objective testing and his death. (CX 2, Exhibit 5, 9, 10; EX 5 at 15-16)

<sup>&</sup>lt;sup>12</sup>Although Dr. Bassali's x-ray interpretation, in and of itself, might not have warranted a finding of complicated pneumoconiosis under §718.304(a), with the benefit of hindsight from the autopsy evidence, credence can be given to his positive x-ray reading of complicated pneumoconiosis.

which were due to the Claimant, James B. Whittington, should be paid in accordance with §725.545(c).

## Attorney's Fees

Claimant's counsel is allowed thirty days to for the submission of an application for an attorney's fee pursuant to §§725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

#### **ORDER**

The claim of James B. Whittington for black lung benefits under the Act is granted. Respondent Cypress Amax Minerals Co., the Responsible Operator, shall pay all benefits to which James B. Whittington was entitled under the Act, for the period from June 1, 1993, to October 31, 1997, as provided in §725.545(c). Respondent shall reimburse the Black Lung Disability Trust Fund for payments made by the Fund to the Claimant with appropriate credit for all reimbursement payments made. The Respondent shall pay interest on all past due compensation payments owing under this award at the rate prescribed by 28 U.S.C. §1961, computed from the date that each such payment was due. All necessary computations shall be made by the District Director in accordance with this Decision and Order and the applicable provisions of the Act and regulations.

# EDWARD TERHUNE MILLER Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601*, *Washington*, *D.C. 22013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.